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PAYMENT PRESSURE:
The Impact of Out-of-Pocket Costs on Patients and Providers

PAYING A PREMIUM

More than half of Americans not covered by Medicare—over 150 million individuals—have insurance plans offered through an employer,[1] according to the Kaiser Family Foundation and the Health Research & Educational Trust (HRET).

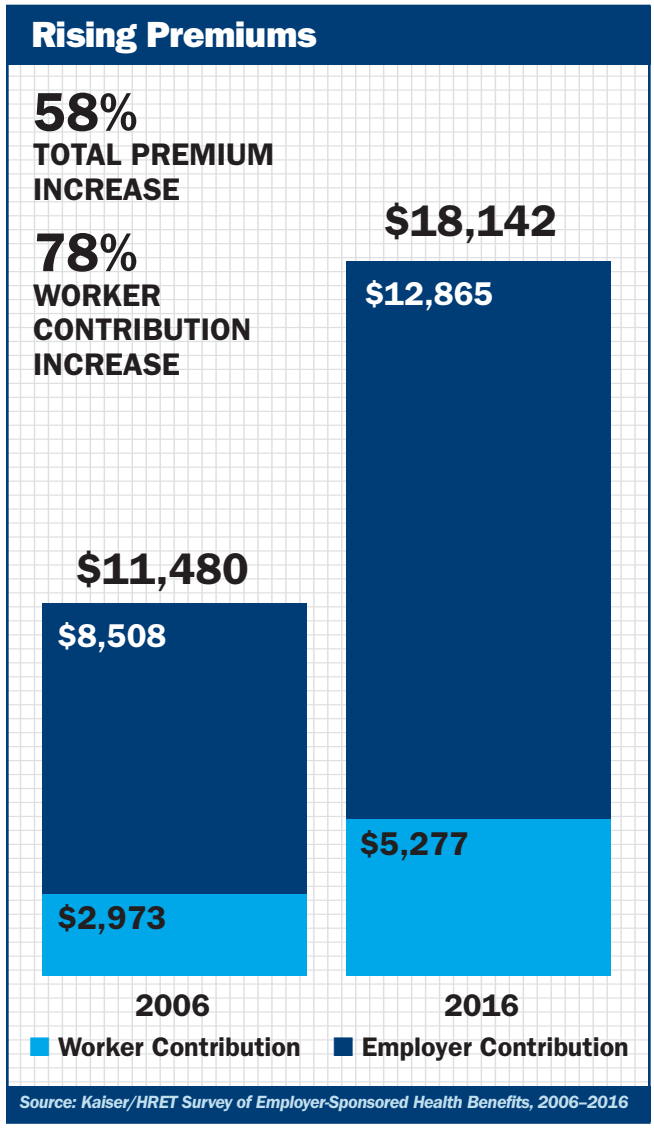
Furthermore, average insurance premiums for employer-sponsored family coverage in 2016 rose 3 percent vs. 2015[2] During the same period, wages rose more slowly (2.5 percent), and inflation increased 1.1 percent.[3]

More tellingly, this relatively modest annual increase caps a long period of soaring costs, with premium costs rising 20 percent since 2011 and 58 percent over the past decade.

While many employers (especially larger organizations) cover a portion of premium costs, employee contributions have risen even faster than overall premiums, increasing by 28 percent since 2011 and 78 percent since 2006.[5] Insured individuals who do not receive their coverage through an employer have seen rising costs as well. On the eve of the Affordable Care Act's open enrollment period in 2016, the U.S. Department of Health and Human Services (HHS) reported that premiums for benchmark health plans offered through Healthcare.gov would rise 25 percent in 2017.[6]

PAYING MORE OUT OF POCKET

Beyond premium costs, insured Americans are paying higher direct costs in the form of higher deductibles. The National Center for Health Statistics reported that during the first



quarter of 2016, 40 percent of individuals covered by private insurance were enrolled in high-deductible health plans (HDHP). This represents a steep increase over a span of just five years, as only 25.3 percent of private insurance holders had HDHPs in 2010.

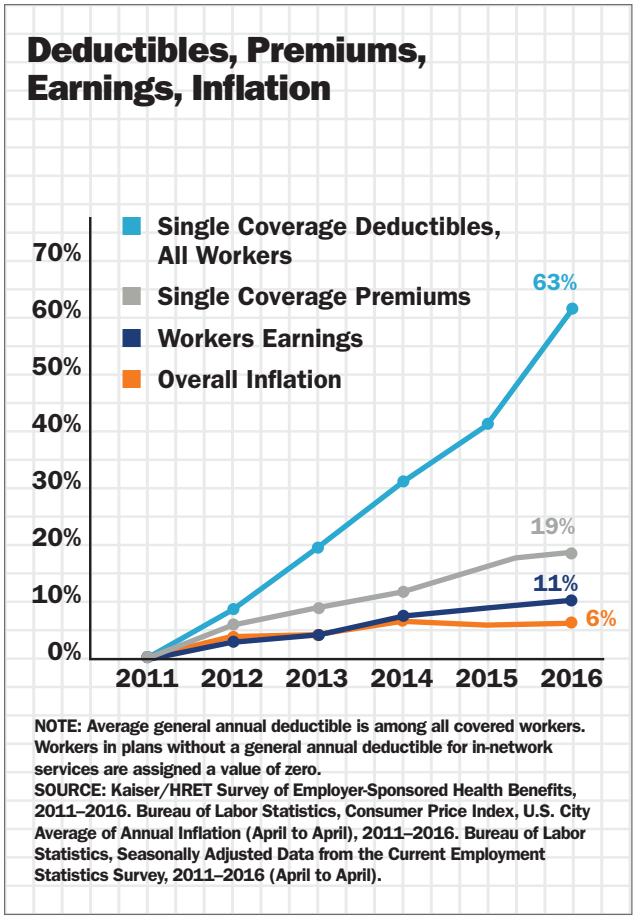
Not surprisingly, the increasing prevalence of HDHPs has contributed to a surge in overall deductible costs across plans of all types. A 2016 Kaiser Family Foundation study found that 83 percent of people with employer-sponsored insurance have a deductible of some kind, and 51 percent overall (and 65 percent of those working at small companies) face a deductible of $1,000 or more (vs. just 10 percent in 2006). In the past five years, deductible costs for individuals with single coverage have increased three times more than premiums, nearly six times more than wages, and ten times more than inflation.

In addition to deductibles, the insured often face out-of-pocket charges such as coinsurance. During the decade from 2004 to 2014, spending on deductibles rose most dramatically (256 percent), but coinsurance payments more than doubled (107 percent), while wages increased just 32 percent, the Kaiser Family Foundation found. Many plans also involve copays, which actually declined 26 percent over the same time span. This is welcome news for patients, though it does little to offset increasing costs elsewhere. In addition, copays are often flat, relatively low fees incurred over time, while coinsurance can be a much higher charge resulting from a single incident.

STRUGGLING TO PAY

Rapidly increasing costs related to healthcare and lackluster growth in wages have led many patients to a precarious financial position. A 2016 Kaiser Family Foundation report found that more than a quarter of U.S. adults under the age of 65 found medical bills difficult or impossible to pay in the past 12 months.[1] While this struggle is more common for those without insurance (53 percent), in nearly two-thirds of cases (62 percent), the patient had insurance coverage at the time care occurred.[2] A separate 2016 study by The Physicians Foundation stated that more than two thirds (67 percent) of adults are concerned about being able to pay for medical care if they experience an injury or illness.[3]

Unmanageable costs for medical care can be driven by predictable causes such as



costly emergency room visits and hospitalizations, but more commonplace expenses are also creating difficulty, including doctor visits and diagnostic tests (each cited by 65 percent of individuals), outpatient services (49 percent), and dental care (41 percent). Among those with insurance, fully three quarters (75 percent) reported struggling with high out-of-pocket costs due to deductibles, copays, or coinsurance.[4]

A 2015 Consumers Union survey also found that nearly a third of Americans with insurance faced unexpected medical expenses due to limited insurance coverage.[5] In many cases, care delivered by out-of-network providers resulted in "surprise medical bills." A recent Kaiser Family Foundation study found out-of-network charges were involved in roughly one third of cases when insured, non-elderly adults struggled to pay medical bills.[6]

PROVIDERS UNDER PRESSURE

Just as patients are facing skyrocketing costs and extraordinary pressure, profound changes in the healthcare and insurance industries have taken their toll on care practices as well. Even navigating shifts in care delivery and compensation models can be challenging. To take primary care as an example, nearly two thirds of physicians (and 87 percent of nurse practitioners and physician assistants) are compensated in ways besides traditional fee-for-service, including capitation (payment per patient), patient-centered medical home, and advanced primary care practice models, according to a 2015 Commonwealth Fund report.[7]

Driven by increasing financial concerns, patients are also approaching health care decision-making differently. The trend of "health care consumerism" is leading potential patients to demand things like estimates for care expenses, cost comparison tools, and detailed billing, according to a 2016 report in Becker's Hospital Review.[8] A McKinsey & Company report explains that patients are increasingly approaching medical care spending the way they do other financial decisions, raising expectations for availability and clarity of information, online tools, and customer service.[9] The same report finds that patients are also increasingly aware of (80 percent) and open to (72 percent) receiving care in non-traditional settings, such as retail stores and pharmacy chains.

The combination of increased variety and complexity of payment models, rising competitive pressure, and greater patient expectations for cost information and resources has a powerful cumulative impact. The need to invest more time and resources to business tasks like sales and billing has driven

a surge in practice consolidation and acquisition in recent years. A September 2016 Leavitt Partners study found that the number of physicians in small practices decreased (from 40.1 to 35.3 percent), while the number in very large practices increased (29.6 to 35.1 percent) in just two years.[10] This finding represents an acceleration of a longer-term trend; from 1983 to 2004, solo offices declined from 41 to just 17 percent of all practices, while groups with 25 or more physicians rose from 5 to 20 percent), according to The Commonwealth Fund.[11]

For small solo practices and larger groups alike, devoting greater time and effort to billing and collections is increasingly common, but providers continue to wait longer to receive less. According to the Medical Group Management Association (MGMA), it takes 3.3 billing cycles, on average, to receive payment in full, and when bad debt is passed along to collections, providers only receive $15.77 for every $100 they are owed.[12] This is not surprising, as collections agencies are not always successful in securing payment. A 2014 report in Medical Economics notes that fees for doing so can amount to up to 50 percent of the payment amount.[13]

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AN ARRAY OF APPROACHES

Due to the pervasive presence and significant impact of the trends described above, a number of options have emerged to help practices address today's challenges. These options vary significantly in terms of complexity, cost, disruption, impact, and other attributes, so a high-level review of common approaches can be a useful starting point before proceeding to vet specific solutions.

Generally speaking, practices implementing changes to improve issues related to billing management, accounts receivable, and patient payments tend to focus on one of four main approaches:

Processes—Operational and/or personnel changes, such as hiring staff to focus on insurance and billing, or changing how and when payment conversations and requests happen.

Partners—Third-party vendors, such as billing and collection agencies who pursue payment on a provider's behalf.

Platforms—Technology offerings, such as tools that allow patients to access records, view costs, and pay bills online.

Payments—Expanding payment options, such as accepting new forms of payment or allowing patients to pay over time.

THE PROMISE OF FINANCING

While all of the approaches described above offer advantages, each also entails significant limitations. In contrast, an ideal option would

combine the benefits of all of these approaches, without the drawbacks inherent to any. One solution that offers this kind of promise is health care financing.

Rather than cover a large medical expense by paying with cash, draining a checking or savings account, or using a traditional credit card needed for other expenses, patients can draw on a separate, dedicated credit card account that makes it easier to manage their health care spending. For larger expenses, patients may be able to take advantage of promotional financing offers—such as 6, 12, or 18 months with deferred interest, or equal monthly payments with a reduced interest rate—allowing extensive time to pay a medical bill while managing costs. Cardholders receive monthly statements, can call dedicated customer service representatives for answers and assistance, and have access to a secure online portal to manage their account details (including making payments).

By partnering with a vendor that offers health care financing such as CareCredit, practices can eliminate many of the most troubling challenges associated with patient billing. Once a transaction occurs, the provider receives payment within two business days, which helps practice cash flow, reduces accounts receivable, and all but eliminates costs and effort associated with ongoing account management and invoicing.

Even when patients choose to take advantage of special financing promotions, the practice receives payment up-front. In the case of CareCredit, the company assumes responsibility for both follow-up communications, and risk associated with missed or late payments. In a worst-case scenario, if a patient ultimately is unable or unwilling to pay, the provider still is not liable, which will thus not affect the practice's balance sheet.

CareCredit has 10.5 million cardholders. To learn more about how easy it is to join more than 200,000 enrolled locations, visit www.carecredit.com/hcpayments today.

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